Reference number(s)
5590-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control – Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty – Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☑

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☑
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Multiple Myeloma

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty – Choice Formulary (ACSCF), Value Formulary (VF), and Value Formulary Chart (VFC).

Plan Design Summary

This program applies to the multiple myeloma products specified in this document. Coverage for targeted products is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are new to treatment with Kyprolis for the first time and to all members requesting treatment with branded generic bortezomib.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Multiple Myeloma Therapies

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Products
Preferred	• bortezomib (generic) • Ninlaro (ixazomib)
Target	• bortezomib (branded generic) • Kyprolis (carfilzomib)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for the preferred product.

- Coverage for Kyprolis is provided when either of the following criteria are met:
  - Member is currently receiving treatment with a targeted product, excluding when the requested targeted product is obtained as samples or via manufacturer's patient assistance programs.
  - Member has a documented inadequate response or intolerable adverse event with both of the preferred products.
- Coverage for bortezomib (branded generic) is provided when both of the following criteria are met:
  - Member has a documented inadequate response or intolerable adverse event with Ninlaro.
  - Member has a documented intolerable adverse event to bortezomib (generic), and the adverse event was not an expected adverse event attributed to the active ingredient as described in the prescribing information.

References

1. Ninlaro [package insert]. Lexington, MA: Takeda Pharmaceuticals America, Inc.; July 2024.
2. bortezomib [package insert]. Lake Zurich, IL: Fresenius Kabi; April 2022.
3. Kyprolis [package insert]. Thousand Oaks, CA: Onyx Pharmaceuticals, Inc.; June 2022.